

"escapes from the closet." Dr Fox's capsulization of his quandary should certainly help broaden the understanding of the issues involved.

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Cognitive-Procedural Differences

TO THE EDITOR: The letter¹ by Stephen D. Leonard, MD, on the concept of cognitive versus procedural care that was published in the February 1987 issue is as remarkable for its prejudice as it is for its ignorance.

The American Society of Internal Medicine and others have unceasingly pointed out that *all* physicians do cognitive work. The question is not that one kind of physician is smarter than the next, but rather that remuneration is so unequal when procedural and nonprocedural services are rendered. This has led to an increasing disparity in income between the primary care and other branches of medicine.

Attempts to adjust cognitive-procedural differences are really an attempt to *avoid* a war among the branches of medicine by making adjustments that bring remuneration more into line with the resource cost of producing medical services.

There may possibly be a better way of labeling the problem than calling it "cognitive-procedural," but to treat it with contempt is to virtually say "Let them eat cake." Who is it, then, who is trying to produce discord within the house of medicine?

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Illness From Organophosphate Exposure

TO THE EDITOR: The comparison of cholinesterase values before and after oxime administration, suggested by Izraeli and co-workers,¹ is a clever approach to the confirmation of organophosphate-induced pesticide illness in the absence of preexposure cholinesterase values.

This method will not work in all cases, however.

Persons who become ill after exposure to organophosphates may receive pralidoxime without any substantial effect on their cholinesterase levels, if they have had chronic exposure to these pesticides. This would result from preexisting but nonsymptomatic inhibition of cholinesterase activity—that is, a patient with a substantial portion of the enzyme already irreversibly bound to insecticide.

Neither this method, nor the method we have described,² overcomes the limitations of the cholinesterase analysis, which preclude it from being the means of excluding the diagnosis of pesticide poisoning. Carbamate insecticides cause cholinesterase inhibition and cholinergic symptoms, but such inhibition cannot be detected by a cholinesterase analysis, as the bond between enzyme and insecticide is so labile that activity is restored by the analytic procedure. We wonder whether the test may be inadequate to detect symptomatic but mild cases of organophosphate-induced illness as well.

Izraeli and co-workers have, however, provided another useful clinical tool. A minor criticism of their letter is to note that oxime therapy does not necessarily reactivate erythrocyte cholinesterase to a greater degree than plasma cholinesterase. In some cases, it is the plasma cholinesterase that has shown the greater reactivation.³ This is not surprising in that some pesticides inhibit plasma cholinesterase more dramatically than the erythrocyte enzyme.⁴

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Educating the Public About Life-Style and Nutritional Practices

TO THE EDITOR: I would like to make some comments regarding the article in the Forum section entitled "Educate, Educate, Educate" by R. W. Odell, Jr, MD.¹ I heartily agree with Dr Odell that the funding of our health care is forcing a long needed reappraisal of values we as physicians have taken for granted. I also agree that a competent physician educates his or her patients as part of his or her treatment. He states, "American medicine will regain its preeminence in our society only in so far as it reassumes this vital function of educator about matters medical. This will require brutal honesty and much soul searching, for past deficiencies are not easily made up."

I would differ with him, however, on where the emphasis should be on education. All of the things that he points out I think are valid. However, we as physicians must come to the realization that the great majority of our major illnesses are largely self-inflicted by self-destructive life-style and dietary habits. They are, therefore, largely preventable. Our emphasis in medicine has been largely on diagnosis and treatment of established disease. As long as we continue to place the emphasis on ever more sophisticated means of diagnosing and treating diseases, we are only going to drive up the cost of health care. We must find a means of reducing the supply of sick patients. Even the National Cancer Institute has acknowledged that we do not need a single new breakthrough in diagnosis or treatment. If we could just put into practice what we already know about diagnosing and treating disease, and particularly what we know about preventing cancer, and the same may be said of cardiovascular disease, we could greatly reduce the death rate from cancer by the turn of the century. We have already seen a significant reduction in age-adjusted death rates from coronary artery disease as the public has become aware of the relationship of smoking, diet and exercise to cardiovascular disease. Currently in the United States, nearly one half of all people succumb to a single disease process, namely, atherosclerosis, the underlying cause of most heart attacks and strokes. We certainly have sufficient evidence now to realize that atherosclerosis can certainly be minimized if not eliminated by appropriate life-style and dietary practices.